At this time all participants are in a listen-only mode. There is no question and answer period on the phone line today. Today's conference is being recorded. If you have any objection you may disconnect at this time. And now I'd like to turn the conference over to the Commander, Meena Vythilingam.

Good afternoon and thank you for joining us today for the July webinar. My name Commander Meena Vythilingam. I am a Board certified psychiatrist in the Public Health Service and the Deputy Director of the Deployment Health Clinical Center. I will be your moderator for today's webinar.

We are fast approaching the participant limit for our first Adobe Connect room, so please connect through our second Adobe Connect room at http://dcoe.adobeconnect.com/webinarjuly2013alternate. All that is one word. I know that's a long one, so I'm going to say that again. So it's http://dcoe.adobeconnect – one word - .com/webinarjuly2013alternate/.

So before we begin, let's review some of the webinar details. I will be moderating this webinar. And today we are going to use a different and a new format. Instead of a didactic lecture, Dr. Hobe (sp) and I will have an in-depth discussion about the details of DSM-5. The good news is that PowerPoint slides will be kept to a bare minimum in this presentation. Live closed captioning is now available through the Federal Relay Conference Captioning. Please see the pod beneath the presentation slides. Today's webinar is hosted using Adobe Connect and Defense Connect online platforms. Should you experience technical difficulties, please visit dcoe.health.mail/webinars to access troubleshooting tips.

There may be an audio delay as we advance through the very few slides in this presentation, so please be patient as the connection catches up with the speaker's comments.

During the webinar you are welcome to submit technical content related questions via the Question box. The Question box is monitored throughout the webinar, and questions are forwarded to our presenter for response during the question-and-answer session held during the last half hour of this webinar. Our presenter and I will respond to as many questions as time permits.

DCoE's awarding of CE credit is limited in scope to healthcare providers who actively provide psychological help and traumatic brain injury care to active duty U.S. service members, reservists, and National Guardsmen, military veterans, and/or their families. To qualify for the receipt of CE credit from St. Louis University, you had to register prior to Monday, July 22, 2013, at 2359 hours Eastern Standard Time. The authority for training of contractors is at the discretion of the chief contracting official. The webinar is approved for the following CE credit: 1.5 AMA PRA Category One credits, 1.75 CE contact hours, physical therapy and occupational therapy, 1.5 nursing contact hours, 1.5 social work CE hours, and 1.5 APA credit hours for psychologists. For complete accreditation statements, visit dcoe.health.mail/webinars. If you meet the eligibility requirements and preregistered on or before Monday, July 22, 2013, at 2259 hours, please visit conf.swankhealth.com/dcoe at the conclusion of the webinar to complete the online CE evaluation and download your CE certificate. The Swank HealthCare website will open immediately following the webinar and will remain open through Thursday, August 1, 2013 at 11:59 p.m. If you did not register, you will not be able to receive CE credit or a certificate of attendance for this event.

I will now move on to today's webinar topic, DSM-5, Revisions and Implications Related to Posttraumatic Stress Disorder. The Diagnostic and Statistical Manual of Mental Disorders, DSM, is a common language to describe psychopathology and lists standard criteria to help classify mental disorders. The Fifth Edition of the DSM was published by the American Psychiatric Association in May 2013 and contains changes to the diagnostic criteria for several disorders, including posttraumatic stress disorder and acute stress disorder. The updates in the DSM-5 were influenced by new research findings and field trials that

empirically demonstrated the reliability of several of the new criteria. This webinar will highlight overall differences in the DSM-5 approach to mental disorders compared to DSM-4 TR, will describe key changes in the various categories of mental disorders in DSM-5, and elaborate on the updated criteria for posttraumatic stress disorder and acute stress disorder.

So today's presenter is Dr. Charles Hoge. Dr. Charles Hoge is a graduate of Sarah Lawrence College and University of Maryland School of Medicine. He received specialty training and Board certification in Internal Medicine, Infectious Disease, and Psychiatry. That's three Board certifications. A little known fact is that he served in the U.S. Public Health Service prior to his 18-years in the Army. He directed psychiatry and neuroscience research at the Walter Reed Army Institute of Research, that's rare, from 2000 to 2009. Dr. Hoge currently works as a Senior Scientist and Neuropsychiatry Consultant at the Office of the Army Surgeon General, and rare, and is an attending psychiatrist at the Walter Reed National Medical Center. Dr. Hoge deployed to Iraq in 2004 and as a civilian to Afghanistan in 2011 Dr. Hoge has authored more than 100 peer-reviewed articles, 20 of which have been published in high-impact journals such a *JAMA*, *New England Journal of Medicine*, and *Lancet*. He has also published a self-help book for combat veterans and their families. Welcome to this webinar, Dr. Hoge.

Thank you. Pleasure to be here.

So let's start with the big picture, DSM-5. What is your overall impression of the changes made in DSM-5? I think one big concern is are clinicians going to have difficulty switching to the new criteria after using DSM-4TR for 13 years?

Right. Yeah. Well, I'm on the steep part of the learning curve just like probably everybody out there in the audience is, and just a little disclaimer, anything I say here is my personal opinion based on, you know, grappling with reading through this as quickly as I could before this. But it is my personal opinion and it's not official position of DOD or the Army or any of the agencies involved in producing this.

So to answer your question, overall I think clinicians – it's not going to be that difficult for clinicians to assimilate to the new changes in the DSM. There are a lot of changes, but the changes are, you know, really bring a more modern conceptualization to mental disorders, bring in a lot of neurobiology. There's a lot of great changes in terms of neurodevelopmental disorders, neurocognitive disorders. And a lot of the core diagnoses that we use in day-to-day practice really have not changed in terms of the symptom criteria, the number of symptoms, the wording of symptoms, you know, a lot of the time core specifiers or the severity specifiers, a lot of that stuff has really not changed much. And in particular disorders like major depression or disponia, bipolar disorder, schizophrenia, OCD, generalized anxiety disorder, panic disorder, ADHD, these, if you look at the criteria of DSM-5 compared to DSM-4, by and large they're almost identical with just very subtle changes that make sense, those changes make sense. So I think that overall clinicians are going to be able to assimilate to the new DSM fairly well.

Great. So it sounds like although the majority remains the same, there are substantial changes in some of the categories. So can you highlight and elaborate on some of these substantial changes in a few categories in the DSM-5?

Yeah, the ones that I was particularly interested in, and some of the major changes are in, as I mentioned, the neurodevelopmental disorders, including autism spectrum, which is combined diagnoses that were broken into separate categories, four separate categories are now included in autism spectrum. Neurocognitive disorders is a complete revamp of the whole approach to dementia. There's even changes in the delirium diagnostic section, all of which have good rationale in terms of neurobiology as far as I can see. There's changes in sleep disorders. There's very healthy things like specific

polysomnography, diagnostic criteria for sleep apnea has been included, anorexia nervosa has been updated with body mass index instead of body weight. So, you know, kind of highlights are neurodevelopmental, neurocognitive, sleep disorders, and there have also been some changes to substance use disorders and PTSD. We'll talk more about those.

Right. So it sounds like the DSM-5 group has incorporated some of the research findings and some of the biological biomarkers to some degree into the DSM-5 to update some of the categories. Is that a fair statement?

Right. For instance, the anxiety disorders chapter has been broken into three chapters, three separate chapters. There's now anxiety disorders, sort of fear based, phobias generalized, anxiety, panic is in one chapter, you know, the classic anxiety disorders. There's trauma spectrum disorders, and then there's OCD in its own chapter.

Right.

And a lot of that is driven by neurobiology and neuroimaging studies and so forth that suggest there are differences that make those kind of categorizations meaningful.

Right. So we'll have – later on in the webinar we'll dig deeper into some of these categories. But before we start drilling down into the details, I was struck by the fact that the multi-axial diagnostic system is no longer there in DSM-5. So what exactly happened? How did it just disappear? How does that work?

Well, for my understanding, I mean the axial system really was a unique way of classifying diseases that really was not consistent with any other medical classification system, was not consistent with the IC-9 system of classification of disorders. And also there were problems with it. You know, the global assessment of functioning score really did not have good validity. I think that there's not necessarily a reason to put personality traits or personality disorder, you know, or write the word deferred, you know, on axis two, I don't think that's necessary for everybody. And so there was some, I think, some pretty good, pragmatic, reasonable reasons why we really don't necessarily need the axial system to bring psychiatry in with the rest of medicine.

Right. Okay. So I think you've covered the overview and some of the main changes and what categories have continued to be similar. Let's start looking at individual categories. So let's start – you mentioned that the substance use disorder category has changed quite a bit. Can you tell us, talk to us more about what changed and how it affects an average clinician?

Right. So the substance use disorder category, dependence and abuse have been merged. And those terms, dependence and abuse, are no longer in the DSM-5. But if you look at the actual symptoms, you know, they've taken all of the four abuse symptoms, one of which they've removed, which is the legal, you know, having legal problems related to substance use. But the other three are there. And they took all of the original symptoms of the dependence category and they also added craving. To make a long story short, they've really put together the abuse and dependence symptoms that we're all familiar with, with a few minor changes with the addition of craving and the removal of one symptom, they've integrated them into one category, substance use disorders. And then they've created a mild, moderate, severe specifier depending on the number of symptoms someone has that probably pretty well maps to what we thought of previously as abuse and dependence. There's very good research to back up these changes, and from what I can see, you know, looking at the substance use category, I think, again, it's going to be relatively easy for clinicians to make the switch because most of the symptoms that they're familiar asking about are still in the system and they're still on the diagnostic categorization.

Right. So, you know, I think I'd be curious to know if the mild maps to abuse and the severe maps to dependence, you know, how to handle the moderate category.

Right. Yeah, and I think they think two to three symptoms out of the total list, I think there's 11 symptoms total, and that two to three symptoms is considered mild, which is fairly similar to what you had before with abuse, which was, I think, one of four symptoms. And the moderate and severe, moderate is greater than four symptoms and severe I think is cut off it's at six symptoms. And for the IC-9 category they've mapped the mild to the old abuse code.

I see.

And they've mapped the moderate and severe to the dependence code.

I see. I see. So the moderate and the severe would fall more to be equivalent to dependence –

Right.

And the mild would be equivalent to the abuse.

Right.

Got it.

But I think that it's healthy actually not to necessarily think of it that way but to really think of these as one category, substance use disorders. I mean the fact of the matter is that there are a lot of individuals who are on prescribed medications, that are taking their prescribed medications according to the way they're prescribed, and in fact develop tolerance and dependence. And there were problems with the use of, you know, once they received that label of, you know, for instance, prescription drug dependence, that had sort of a pejorative connotation.

Right.

And I think that was – this is one way to sort of look at things a little bit differently.

So your impression is that this is a clinically useful upgrade of sorts?

Right. Yes. I think there's very good evidence to back these changes up.

Okay. Let's shift to somatoform disorders category. What is your impression of the changes in somatoform disorders category in the DSM-5?

Well, somatoform is interesting. The term somatoform, somatization, hypochondriasis, and even pain disorder are gone from the new DSM-5. And these are also very healthy changes. If you look at primary care settings, a large percentage of the symptoms that patients experience and report in primary care settings are unexplained or not fully explained. But the previous definitions for somatization, somatoform, hypochondriasis, those had sort of the connotation if a clinician, you know, used that label it had the connotation of the symptom is in your head and isn't real. And so a lot of times that created potential problems clinically when treating patients with symptoms. So the entire focus in that chapter has shifted toward really a focus on individuals who are experiencing somatic symptoms for whatever the cause is. It could have medical cause, it could have some psychological causes, but if they are experiencing significant distress from that symptom, then they would be categorized as having a somatic symptom

disorder. So I think, again, these are very healthy changes that are very much aligned with what the latest knowledge of these conditions in the primary care setting.

So medical condition is not an exclusion criteria. You can have a medical disorder –

Right.

And a somatic disorder.

Absolutely. Absolutely. Yeah.

So that's very helpful, because this category has always been confusing for me, so that's very helpful. Thank you for that.

So let's shift to personality disorders. Now I was under the impression that there was going to be an entirely new paradigm shift with a dimensional approach for classifying personality disorders, but it looks like in the final cut of DSM-5, we're back to the usual categorical approach for classifying personality disorders. Tell us what happened with this whole section. It looks like it was controversy prone.

Yeah, and the attempt to go to a more dimensional approach received a lot – there was lots of debate about it, and in fact so much debate that two of the subcommittee members who were working on it resigned, publicly resigned.

But can you tell us what you mean by dimensional approach?

Well, with dimensional approach, so, for instance, everyone falls – the idea is everyone falls on a spectrum of, for instance, their ability to have, you know, empathy, for instance, or the ability to have intimate relationships, and so everybody sort of falls on a spectrum, and the idea with the dimensional approach was to rate everybody in terms of their ability to, you know, sense of self, for instance, intimacy, and other characteristics, and then within that group identify some cutoff area where, you know, you could still consider someone to have the disorder or not. And I think that's where the problem arose, from what I can tell, in terms of the debate, is sort of where do you draw that line.

So there's actually two personality disorder sections in DSM-5. They left the main section of personality disorders essentially unchanged from DSM-4. That' the one that's in the main part of the text. And then in the back of the book in the research section is the proposed dimensional approach, which has dimensions and traits and facets of personality and you can look in there and see if you will find that useful. I'm sure that there will be a lot of research related to that.

Right. And depending on what research comes up, it might inform DSM-6.

It might inform DSM-6, exactly.

Okay. So I'm going to shift from personality disorders to depressive disorders. Now I looked over the DSM, and it looks like there's a whole new diagnostic category under the depressive disorders. What is this new diagnostic category and can you tell us what this new diagnosis is?

So one of the things that has happened in the new DSM is they've taken a more developmental approach, so each chapter has – what was previously in a separate chapter of disorders start in childhood and adolescence are not integrated into their respective chapters. So the first diagnosis in the depressive disorder section is called disruptive mood disregulation disorder. And this is based on the knowledge that over the last several years there has been a huge uptick in the diagnosis of bipolar

disorder in children, that is often inappropriate. The individuals who have irritability and, you know, serious behavioral discontrol, temper outbursts, these kids who have temper outbursts and irritability, a lot of these kids have been getting labeled as having bipolar disorder, but this condition of this behavioral discontrol is actually much more aligned with anxiety disorders and other depressive disorders in terms of their prognosis, genetic family history, and also treatment. So it has a lot of treatment implications. So this was an effort, and we'll see how it works because this is a new condition and we don't really know what the validity of this is going to be, but this is an effort, really, to reign back the kind of runaway bipolar diagnoses that have been occurring in kids that often lead to the use of mood stabilizers, use of antipsychotics in children. Again, this isn't my area of expertise, I'm not a child psychiatrist, but –

Right.

It is an important disorder that they put in there.

But I think you make two interesting points. One is the developmental view within each diagnostic category.

Within each diagnostic category.

So, you know, so disruptive mood disregulation disorder is now within the depressive disorder spectrum.

Right.

And this, hopefully, will address the overmedication – medicating kids with antipsychotics.

Right.

We'll have to see.

Exactly. That's the goal.

Yeah.

That's why it was done. And there's good, again, good research. The rationale for it is, you know –

Solid.

There is solid rationale for it.

Okay. I know looking at the depressive disorders category, it seems there are a few more changes buried in there. Can you talk a little more about what other changes have happened in the depressive disorders category?

Yeah, I mean, by and large, for instance, major depression is really essentially the same. If you look at the symptoms, the way they are worded and so forth, they're identical to previous – there have been some changes to like the bereavement exclusion was removed. But then there's been some changes in the specifiers. There is now a depression with anxious distress specifier that you can add. There's a depression with mixed features, if there's some features of manic symptoms but they don't reach criteria for manic, then there's a mixed features specifier rather than a mixed manic state in the previous version. And then peripartum instead of postpartum depression, recognizing that depression can start at any time during peripartum rather than just after.

And then another change was the premenstrual dysphoric disorder is now in the main part of the depression section rather than a research criteria, so that was moved from the research criteria section in DSM-4TR up to the depression section. It hasn't really changed in terms of the actual criteria.

Right.

So, you know, you mentioned the bereavement exclusion is no longer there in the DSM-5. I recall there's been a lot of debate about this, with experts including Allen Frances saying that DSM-5 pathologizes bereavement. Can you talk a little bit more about this bereavement, why is this no longer an exclusion for diagnosing major depression?

Well, I mean, my read of the section – there's actually a much longer footnote within the depression category, and actually within other disorders as well, there is a much longer footnote that talks about bereavement, and I think the footnote is helpful to clinicians in thinking about, you know, whether the concerns are related to bereavement and depression. So there's not an exclusion but there is quite a bit more added in terms of that. I think that there's, again, reasonable reasons, the loss of a loved one is a major life stressor that can lead to major depression, can trigger major depression, and the course of individuals who develop major depression, even in the early aftermath of a loss, can be significant and can have the same sorts of outcomes as depression in other circumstances. So it recognized the fact that some individuals may need to be treated. I don't think that this is going to lead to over pathologizing bereavement, I think, again, because they've done a very careful footnote there about bereavement. I think one of the interesting things about bereavement is in the research criteria there's a new condition listed as persistent – I think it's persistent complex bereavement disorder. And it's a disorder characterized by longing or thinking about the individual who's passed or the circumstances around the death, and then there's a set of 12 criteria listed. But if you look at that criteria there's actually quite a bit of overlap with PTSD symptoms, so I think that it will be interesting to see in the future how these conditions overlap and whether the new persistent complex bereavement disorder is going to be helpful in terms of treating combat veterans, avoidance, emotional numbing, and various other symptoms are included in that bereavement category.

Right. So it sounds like bereavement is treated any other life event that could precipitate depression.

Exactly.

And you don't think that it pathologizes normal bereavement.

I don't see that in the way they handled it. I think they handled it pretty well. That's my take, my personal take on it.

Okay. You mentioned the anxiety disorder category has been chopped into three different sections, you know, fear-based anxiety disorders, OCD, and trauma-based disorders. I'm curious about before we go into PTSD, I want to know more about why OCD was carved out of the anxiety disorders home. Can you talk a little more about that?

Well, again, I think there was some neurobiology and neuroimaging reasons to do that. And then there are some other conditions that involve repetitive behaviors. Body dysmorphic disorder where there's a constant focus on one's body image. Trichotillomania, which is hair pulling disorder. Hoarding disorder, which is a new one that they put in here. And excortiation disorder, or skin picking. And these all have repetitive behaviors that are inherent in them, and I think there was a recognition of similarities with those conditions and OCD. So that's why it was pulled out into one chapter. They do acknowledge in the OCD

chapter that there's really still a very strong anxiety component to it, so it's not like they're saying it's not an anxiety disorder. That's my understanding why they pulled that out.

Some other important changes to anxiety disorders, I mean, in general, the generalized anxiety, panic symptoms, you know, symptom criteria are almost identical, virtually identical. But agoraphobia now has its own diagnosis. So if an individual has panic disorder and agoraphobia, that agoraphobia is not handled as a specifier, they actually receive two diagnoses. And the other thing that they've done is that they've created a panic attack specifier that you can put with any disorder. So now you can list PTSD with panic attacks, for instance, or major depression with panic attacks. And that specifier can be applied. And I think that's, again, a useful change.

Right. From a clinical standpoint, if you, you know most of our patients with PTSD have panic attacks –

Exactly.

And depression is co-morbid with anxiety –

Exactly. Right.

So that makes a lot of sense.

Exactly.

Okay. Any other comments about the anxiety disorders before we shift topics?

No, I think overall they didn't really change that much.

Right.

In terms of the core ones that we diagnose –

Right.

On a day-to-day basis.

So it sounds like although the criteria has not changed, the grouping of the disorders has changed. That is the fear based, GAD, panic has gone to one group. The OCD in another. And then the trauma-based symptoms in another.

Exactly.

Okay. So let's switch to the most important topic on our agenda day, posttraumatic stress disorder. My first question to you is did you serve on the DSM-5 committee and responsible for redefining this disorder?

No. I'm listed in the back of the book. I actually discovered that I was listed in the back of the book when I got the book. I didn't realize I was going to be listed, but I'm listed there as an advisor because we did some research where we compared the PCL17 with a new version of the PCL and looked to see what the differences were. We did this study in infantry brigade soldiers who had been deployed to Afghanistan. And we had some interesting findings. We presented those to the DSM-5 committee, we made some recommendations to them on the basis of that and we presented it at the International Society for Traumatic Stress conference.

So just for the folks who are not familiar with the new version of the PCL, it sounds like the National Center for PTSD updated the PCL based on the DSM-4TR to a new PCL based on the new criteria. Right? And you had a –

I think they're in the process of updating it, or maybe they're nearly finished with updating it, but we had a sneak peak at it early on and so we were able to do a study using sort of the first version of this new PCL which has 20 items instead of 17 items. And we did a direct head-to-head comparison of the 17 items versus the 20 items in our study.

So are you able to talk briefly about the findings when you used the PCL with the new criteria versus the PCL with the old criteria? What happened (inaudible).

Well, it's a little bit – I think that there have been changes since then, so it's a little bit – I'd be cautious in interpreting and saying that this is the way it's going to be going forward, but we actually found a significant reduction in the prevalence of PTSD using the early version of the new PCL. And we identified some issues with wording of specific items on that, but we found that using the old PCL we got a prevalence rate of 15%, which is very consistent with what we've seen in combat veterans. And with the new PCL we got a prevalence rate of only ten percent, so it was about a third lower.

I see.

With the new version. And, again, there have been some changes. We're in the process now of getting ready to repeat that study with an even later version of the PCL and see what we find in the coming months.

Got it. Well, clearly, the PTSD section has changed quite a bit. Can you talk about the big picture changes, major changes, before we drill down into the individual symptoms?

Right. So PTSD's in its own chapter now, trauma and stressor-related disorders chapter, and that includes two childhood disorders, reactive attachment disorder and disinhibited social engagement disorder, which are basically disorders of extreme neglect of children. And it makes sense that they are in a trauma spectrum group. They are there along with PTSD acute stress disorder, and then adjustment disorders got thrown in to the trauma and stressor-related disorder. Clearly adjustment disorders are stressor-related, but I'm not sure if it's necessarily a good fit having adjustment disorders in there. That's a matter of a little bit of debate.

Okay. So let's drill down into some of the criteria for PTSD. So one of the key criteria open to debate is the criteria A, A1 and A2. Can you talk about these A1 and A2, the trauma criteria and tell us what's different in DSM-5.

Yeah, so let me just give you before I talk about the A traumas, just a little bit of the big picture perspective. I think that overall if you look at PTSD, you know, the DSM-4TR definition, and the new definition, by and large they look very much the same. There's still an A trauma criteria that's fairly similar, and then for the new definition there are 20 symptoms instead of 17 symptoms, and they're organized slightly differently, which we'll talk about in a few minutes. But by and large I think that there is quite a bit of similarity between these two.

And then some of the differences are there are some differences which I think are open to question. We'll see how they pan out.

So starting with the A criteria, if we could show slide ten, which is up there now, you can see that the most fundamental change in the A criteria was removal of A2, which was the response of fear, helplessness or horror. The main, you know, what was previously A1 has been reworded slightly but is very similar to what it was before, so exposure to actual or threatened death, serious injury or sexual trauma, and previously I think it said experience, witness or was confronted by an event that involved actual or threatened death or serious injury or threat to the integrity of the self or others. I think that's the way it was before. So you can see that they are very similar in terms of this stem part of this. But then what they've done here is they've added four examples of what this means. And so directly experience an event, witnessing an event, is very similar to what we had previously for the A criteria. And then A3 is learning of an event in a close family member or close friend. But they have tightened this to make it clear that this should be an unexpected death due to an unnatural cause, a violent or accidental cause. So a natural death would not fit into that. And I think there has been a number of instances in which individuals meet the A criteria solely on the basis of exposure to the death that was a natural cause, and the committee really tried to make this a little bit more specific by providing that specific example.

And then the fourth one is repeated exposure to adversive details of traumatic event, and that's really targeting first responders, police, military in this case, and can even include exposure through electronic media if it's work related. And this is an interesting addition. I think that you can look at the old A1 criteria, confronted with an event that involved actual or threatened death. This is sort of an expansion of that concept of being confronted by in a very specific way. And I think it's helpful for first responders and military, but in some ways it broadens the definition of the A trauma criteria. So there's both sort of a narrowing of it in A3 here, but a broadening of it also in A4.

So that's interesting. So it broadens it by the number four, including all the trauma in the line of duty so to speak.

Right.

But it's interesting that there's a qualifier that it says not through electronic media unless work related.

Right. Exactly.

That's kind of interesting. The drone operators would meet this criteria.

They would meet this criteria.

Yeah.

Yeah.

That' an interesting addition.

Yeah. It is. So if you go to the National Center for PTSD website, and the American Psychiatric Association has training for DSM. They've emphasized that the A trauma criterion has become more narrow and more specific. But I think this actually in some ways is a broadening of it.

So it sounds like the criteria that has been removed is causes secondary to natural death, you know.

At least it's been clarified that that should not be included.

That's excluded.

Right. Right.

So in some ways there is a tightening of the criteria, but in other ways there is a broadening of the criteria by the addition –

Perhaps in this, yeah, in this – because I think everybody would agree that exposure to war zone trauma probably meets the A criteria, and this is a way of stating that. But I think – it is a very specific description that in some ways is broader than what people may have thought of before in terms of traumatic events.

Right. So it will be interesting to see the studies on the prevalence of PTSD using the new DSM-5 criteria, and do a factor analysis to see which one is contributing to the differences.

I guess there will be more research on this for sure.

Right. So let's talk about criteria A2 because I noticed that criteria A2, of the reaction to trauma, has disappeared from DSM-5.

Yeah. So A2, which was the reaction, there had to be fear, helplessness or horror at the time of the trauma. There's quite a bit of research showing that that wasn't a very helpful criterion especially for first responders. There was work done by Rare (sp) investigators, Dr. Adler (sp) and others, did very nice work showing that soldiers simply don't report fear, helplessness or horror because they fall back on their training during traumatic events. So there is very good evidence – that was a very good evidence-based decision to remove A2. As far as I'm concerned.

Terrific. So that's a good explanation of the changes in the A criteria. Let's shift to the other symptom clusters. So how have they changed, and what do you think about these changes?

Well, so just in, you know, very quickly to summarize what's happened, there are now 20 symptoms instead of 17. One symptom was removed, the foreshortened sense of future, which didn't have necessarily very good properties and wasn't that helpful clinically, and then three symptoms were added. But they're divided up a little bit differently from there was factor analysis that showed that the avoidance, the seven symptoms that were previously in the avoidance category, that the two pure avoidance symptoms, so avoidance of thoughts and feelings and avoidance of external reminders of the trauma, that those factor differently than the other types of symptoms that were in the category. And so that's now been broken into two categories. So there is the pure avoidance, there are two symptoms in the pure avoidance category. And then the original symptoms that were related to the rest of that category is now in its own category with the addition of some other symptoms.

If you look at how many symptoms you need to meet definition, you still need six. You know, but instead of one re-experiencing, three avoidance, and two hyper-arousal symptoms, you now need one re-experiencing, one of the two avoidance, two of the seven negative mood and cognition symptoms, which is the new category, and then finally the re-experiencing symptoms, two of those.

So it sounds like –

Or hyper-arousal I mean.

Right. So if I recall accurately in DSM-4TR, the cluster of avoidance consisted of the avoidance symptoms as well as the depression symptoms. So it sounds like the avoidance symptoms is now disarticulated from the negative cognition (inaudible).

It has its own – exactly. It has its own category. You have to have one avoidance symptom in order to be –

Right.

To be in the definition of PTSD.

Because in the previous criteria, you could qualify for a PTSD diagnosis without an avoidance symptom.

Right. So let's look – I think it's helpful to look also now at some of the specific wording changes of symptoms –

Right.

And get in the weeds, and we prepared some polling questions, and I'd like to put the first polling question up there. This has to do with the B criteria. And I'd like – it would be helpful if those folks who are clinicians who make the PTSD diagnosis, mental health clinicians and any other clinicians who work in the field who make diagnoses of PTSD, if you all would answer these questions and the rest of you stick with the no vote if that's okay for these polling questions.

These are polling questions asking about what you think about the differences. So let's start with the first one, which has to do with the change in the wording to the B criteria, which is the re-experiencing criteria. Do I read it? Okay, I'm getting a head nod. In your opinion, which B criteria wording is more clinically useful? So the first one is presence of one or more of the following intrusion symptoms associated with a traumatic event beginning after the traumatic event has occurred. And the second is the traumatic event is persistently re-experienced in one or more of the following ways. So what is your preference in terms of clinical utility?

So this is a good way to highlight one of the core changes that have happened is actually removal of the term re-experiencing. So the second one on that list, which actually most people prefer the second one on that list, is from DSM-4TR, and the first one is from DSM-5. And, you know, there may be inherent biases here because people are familiar with these, they know which one – they're used to using these, so there may be some biases in how people are answering these questions based on familiarity, you know, people are more familiar. But I think that this is a notable change. It previously said the traumatic event is persistently re-experienced. Now it says the presence of one or more of the following intrusion symptoms. And, you know, for 25 years we've had the term re-experiencing, we've had very little change in the diagnostic criteria in terms of the symptom criteria since DSM-3R, and so this is kind of a major wording change as far as I'm concerned.

So intrusion versus re-experiencing?

Right. Exactly. And it's interesting how many folks are picking the older terminology as their preference in terms of clinical utility.

Let's go to polling question number two. And again, I'd ask those clinicians who make diagnoses if you all could answer the polling questions.

Polling question two has to do with the B1 criteria, which – so in your opinion, which B1 criteria is more clinically useful? Recurrent and intrusive distressing recollections of the event including images, thoughts or perceptions. And the second one is recurrent involuntary and intrusive and distressing memories of the traumatic event. What's the preference here?

I really appreciate – this is just fantastic being able to do this and get this kind of feedback.

So when you broadcast the results, people can see the numbers, right, that are up there.

Can everyone see the numbers?

Yeah. Okay. That's fine.

So you can see that here again, in this case DSM-4 was the first one and DSM-5 is the second one. So you can see, again, that most people are picking the DSM-4 criteria. And it's notable to, again, maybe this has to do with familiarity because people know which ones, you know, they're used to using these. But it is interesting to note that this is also, in my opinion, a fairly significant change in wording. So DSM-4 said recurrent intrusive distressing recollections of the event including images, thoughts or perceptions. And in DSM-5, it really just talks about recurrent involuntary and intrusive distressing memories. So what about the thoughts? What about the perceptions? Particularly thoughts. If you're thinking, if you're having ruminative thoughts about the event, that's really not the same thing, necessarily, as memories. So whether this is going to prove to be interpreted in a similar manner or not, it looks like, to me, the reading of them, it looks fairly different.

Right. And, you know, are you privy to the data that backed this change? Are you familiar with that at all?

I'm not. Again I think there was a very – you know the removal of A2 was evidence based.

Right.

The movement of avoidance into its own category was evidence based. Very strong research to support. These types of wording changes, I mean, if you look at generalized anxiety, panic disorder, major depression, ADHD, etc., there's virtually not a single wording change in the actual symptom criteria. Come to PTSD and there are fairly substantial wording changes for a lot of items, and these are items that have stood the test of time for 25 years. So are these improvements or not, I think it's an open question.

So let's go to the C criterion, how the C criterion changed. So the C criterion, the new C criteria is the two avoidance questions, so let's look at polling question number three. So in your opinion, which C1 criterion wording is more clinically useful, avoidance of or efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event, or and the second one is efforts to avoid thoughts, feelings or conversations associated with the trauma. Which one is preferable in terms of clinical utility. Again, if the clinicians out there could answer this, that would be great.

We're using the polling questions in lieu of PowerPoint slides to really sort of highlight these differences, so I'll be interested in any feedback you all want to provide on whether this was helpful or not. It's the first time we've tried to do something like this. Are you ready to publish it?

So in this case we have slightly more people answering B, the second is preferable. So slightly more people are favoring the DSM-5 wording of the B1 criteria than the DSM-4 wording. Okay, so in this case people are favoring the DSM-5 wording. And if you look at how this has changed – I'm sorry. Am I doing that right? No.

No, the other way.

People are still – it's the other way around.

Yeah.

So in this case people are still favoring the DSM-4, but not by such a big margin as we saw previously.

Now the thing about this is that conversations is clearly not a thought or feeling. It's more of an external cue, when you're interacting with people that's more of an external engagement, and so in many ways conversation was misplaced in this. So I think that it made a lot of sense to move conversations out of there, but clearly it's a little bit more wordier than it was before. Maybe that's the reason why people are favoring the DSM-4 version is because it's a little simpler. Although I think the decision to move conversations out of there is clearly a good decision. Does that make sense?

Yes.

Okay.

I think this is a great way to make the point that the same particular criteria has changed compared to DSM-4.

Right.

So I have three more polling questions if you all can bear with me. So the next polling question is polling question number four. And it asks, in your opinion, which C2 criterion wording is more clinically useful? Efforts to avoid activities, places or people that arose recollections of the trauma? And the second one is avoidance of or efforts to avoid external reminders, people, places, conversations, activities, objects, situations that arose distressing memories, thoughts or feelings about or closely associated with the traumatic event.

Okay, so in this one it looks like there is a rousing preference for the new criterion, which is the DSM-5 C2 criterion wording. And I think that overall you can see that they probably mean very similar things.

Right.

But it makes sense, I mean, in this case.

But it's interesting how the clinicians preferred the DSM-5 wording.

Right, right.

This is probably the first time –

This is the first one that – yeah. This is the first time. Maybe folks are now catching on to the polling categories or something. But this is, you know, to me this is quite a bit more wordier, but it's also there's quite a bit more detail in there as to what is meant by external events, and so I think in some ways maybe that's why it's being favored.

And I guess it makes sense from a organizational standpoint of view to group it into internal reminders –

Right.

Or external reminders.

Exactly. And you can see conversations is now moved into this category –

Right.

Which is, again, a healthy change.

Okay, next polling question. So that's the C criterion. D criterion. in the D criterion we actually have seven symptoms now out of the original seven, two were avoidance, they moved into their own category, and that left five. And out of those five, one got removed and three got added, so we now have seven symptoms in there. Three of them have really not changed very much, which is the inability to remember important aspects of the trauma, the Ann Hedonia, the decreased interest or participation in activities and the feeling of detachment and estrangement. Those really did not change if you compare the new wording with the old wording.

Right.

As I mentioned, foreshortened sense of future was removed. And then there was one symptom that was markedly reworded and that's what this polling question is about. So let's have polling question number five – is this number five. And this says, in your opinion which wording is more clinically useful, restricted range of affect, unable to have loving feelings, or persistent inability to experience positive emotions, inability to experience happiness, satisfaction, or loving feelings.

Okay, and the posted results are a whopping 80% or more are favoring the DSM-5 wording, and restrictive range of affect, which has been there for 25 years has been, again, significantly reworded here to persistent inability to experience positive emotion. And to me, and I see the crowd is overwhelmingly in favor of the DSM-5 version, to me I think that emotional numbing can span not just positive but also other types of emotions, for instance when individuals have emotional numbing they may have emotional numbing to the grief as well. And so when you talk about positive emotions versus negative emotions and numbing only related to positive emotions, I think there may be some differences in how that's interpreted. So I'm rather, you know, I guess I'm attached to the old wording myself, personally, even though 80% of the crowd seems to be favoring the new wording.

Well this is another example where in a restricted range of affect expand the range of affect. You know, the DSM-4, but now they've cut out the negative emotions, and I'd be very curious to understand why. Because you're right, because this, you are unable to grieve or bereave, that's a restricted range in the negative direction.

Right.

Okay.

So last polling question, question number six. This has to do with the three new symptoms that have been added. And we just created one polling question for this, so in your opinion, will these three new cognition and mood symptoms improve the overall clarity and accuracy of the clinical diagnosis of PTSD? And you can read them here, but I'll read them very quickly. So D2 is persistent and exaggerated negative beliefs or expectations about one's self, others or the world, e.g., I am bad, no one can be trusted, the world is completely dangerous, my whole nervous system is completely ruined.

D3, persistent distorted cognitions about the cause and consequences of the traumatic event that lead the individual to blame himself, herself, or others.

And then D4, persistent negative emotional state, fear, horror, anger, guilt of shame.

Will these likely improve the accuracy and clarity, worsen it, or make no difference?

Ready for posting I bet. All right, so overwhelmingly, again, people think these are an improvement, and I think that there's a lot of things that are buried in these three new items that the people who are working with service members with PTSD know are important issues, so a lot of guilt, for instance, is a very important symptom, guilt and self-blame is a very important symptom. So now guilt – actually guilt used to be, in DSM-3, the DSM-3 definition of PTSD, there was only 12 symptoms. Guilt, you know is actually, specifically survivor's guilt, was in DSM-3. Guilt has now been added back in, and it's really kind of in two questions here. Guilt is included in D4, and it's also included with the self-blame in D3. So that's, I think, in many ways an important change and acknowledges that this is an important symptom.

I think that – some of the other aspects of this, though, concern me a little bit, and that is the overlap with depression. You've got a lot of negative cognitions with depression, and in this case, you know, I think there is going to be a pretty significant overlap potentially with depression, and in fact in our research we found that with the new PCL versus the old PCL we didn't find increased specificity comparing with the co-morbidity and the overlap with depression. We'll see how these turn out.

I think that some of the things with the last symptom, D4, fear and horror, which were part of A2, has now been incorporated in here. Anger is included here but it's also included in the E criteria symptoms.

Right.

The hyper-arousal symptoms, so it's actually in two places now. So in some ways these questions, thought they identify important topics that we commonly see in our clinical practice, they don't necessarily distinguish within themselves, you know, self-blame from blame from others, or guilt from, you know, those are combined into one. Anger is included here, and it's also included in. So in some ways these are maybe not as specific as I would have liked to see them, but they are certainly things that we know are important.

Right. I think you run the risk of meeting criteria in both clusters. If you have anger both in the hyper-arousal as well as the negative cognitions and moods, and I think that's a risk.

Exactly.

I think the other point I wanted to make is I'm just struck by some of these new criteria directly plug in to some of the concepts in cognitive processing therapy, you know, the cognitive distortion –

Right.

And the negative schemas, and so I think perhaps it helps you assess for these symptoms at the beginning of treatment and hopefully will help figure out what kind of psychotherapy might be more appropriate. I'm hoping that will be the case.

Yeah, maybe. I mean some of these seem a little wordy to me. Some of the examples they have quotes around, you know, my whole nervous system is completely ruined, and, you know, I'm not sure patients talk that way, but nevertheless, we do know that individuals with PTSD frequently have these kinds of negative cognitions, they frequently experience guilt, for instance.

Right. Right.

And I would have personally liked to see a pure guilt item.

Right.

I would have liked to see that. I would have preferred if the anger item was left alone in the hyper-arousal section and not added to this, you know, but those are sort of more personal perspective on things.

Okay. So this was a great summary of the changes in PTSD, so I wanted to switch to acute stress disorder in the last five minutes that we have. Can you talk about the changes that we have in this category?

Yeah. In acute stress disorder there has been substantial changes as well. Previously it was you had to have evidence or re-experiencing, evidence of avoidance, and then they had five dissociation symptoms, and you had to have three of those. I think it was numbing, detachment, being in a daze, derealization, depersonalization, dissociative amnesia. Now they've kind of lumped all of the dissociation into one symptom, one dissociative symptom, altered sense of reality, and they've also retained the dissociative amnesia component. And then they've created a list of 14 symptoms that include re-experiencing, avoidance, negative cognitions, dissociative symptoms, and they picked nine out of the 14 symptoms to be the cutoff for acute stress disorder.

I'm not really sure about the evidence to support, you know, is it nine, is it eight, is it more than that, you know, how did this particular list get decided and so forth, but it does look quite a bit different than the old definition of acute stress disorder.

Right. And it will be interesting to see the data on the prevalence of acute stress disorder once this gets rolled out into clinical use.

Exactly. Right.

Okay. You know a frequent situation in clinical practice is a patient might have some symptoms of PTSD and may not qualify for the full syndromal criteria for PTSD, so it would be more subclinical PTSD. So how should a clinician codify the subclinical syndrome of PTSD?

Well the new DSM actually specifically recommends the use of the adjustment disorder code and diagnosis for individuals with subclinical PTSD. I personally think that's problematic because adjustment disorder really has to do with a definable stressor, and if the individual goes on to have prolonged symptoms, lasting, for instance, six months or more, usually that's in the context of the stressor continuing, not the stressor having been a single, for instance, traumatic event that happened in the past. So I have a hard time thinking about it conceptually as an adjustment disorder. I also think that adjustment disorder, particularly in the military, has a somewhat pejorative connotation. Individuals can be administratively separated for adjustment disorder. So and then also the current IC-9 coding system doesn't reflect this change. Previously we used anxiety disorder NOS, the 300 point 00 category frequently to capture subclinical PTSD, and this new change, I guess I'm not very happy with it, if I want to be up front about that.

So there's no PTSD NOS?

Well there is – there is actually – there is actually a other specified trauma disorder and other unspecified trauma disorder, okay, category. So for all of the chapters they've actually, for instance, removed depression NOS, removed anxiety disorder NOS, but they now have, you know, other anxiety disorder specified and other anxiety disorder unspecified, and other depressive disorder specified, using the same codes that they used before for anxiety depressive disorder NOS. And all that – the specified group, all it really says is that for instance if you have, you know, subclinical depression you can use the other specified disorder category, if that makes sense. With trauma, the other specified category, one of the examples, for instance, is cultural syndromes, you know, trauma-related syndromes like (inaudible).

Right.

And, you know, they use that as an example of that other specified trauma condition. But in fact the text doesn't recommend using either of those other categories for subclinical PTSD. And if you look at those codes, those codes are also within the adjustment disorder or adjustment reaction spectrum within ICD-9, they're not necessarily mapped to an other trauma group, so I think this is an area where we're going to have a little bit of growing pains, particularly because our electronic medical record systems are mapped to DSM-4TR.

Right. So it sounds like the adjustment disorder diagnosis has stayed put and has not changed much except for this caveat that subclinical PTSD symptoms have to be categorized as adjustment disorder.

Yeah, that's – that's -

Is that fair to say that?

Yeah, adjustment disorders haven't changed, but oddly enough you can't find the acute and chronic specifier any more in the current published edition. That turns out to be an error, and the American Psychiatric Association is apparently going to be fixing that error. So chronic adjustment disorder is staying put for the time being even though you can't find it in the current published issue of DSM.

Well, Dr. Hoge, thank you so much for your insights and answers to all these DSM-5 questions. If you have any questions, for Dr. Hoge, please submit them via the question box.

It is now time to answer questions from the audience. We are monitoring the question box and will forward questions to our presenter for response. If you have not already done so, you may submit questions via the question box located on the screen. We will respond to as many questions as time permits.

So I'm going to read the first question from the participant. Why was the legal problem removed from substance disorder?

I don't have a good answer. I mean, I wasn't privy to the discussions related to that. I kind of view legal problems as being sort of an end stage functional outcome that can happen, but it's not necessarily a symptom, you know, if that makes sense. But that's probably not a very good answer. Not a very clear answer.

Well I think also it will be interesting to see what the research showed regarding legal problems –

Right.

Which I'm very familiar with. Yeah.

Yeah, one of the changes to the E criteria which I didn't talk about in PTSD was the addition of – let me find the exact wording of it – of reckless and self-destructive behavior. So the original hyper-arousal symptoms are still there, but one has been added, reckless and self-destructive behavior, and we all know that reckless and self-destructive behavior is an important component that can happen to individuals with PTSD, but I sort of, again, view that as an end state sort of functional outcome that's reflective of functioning. It's sort of a measure of functioning, it's not necessarily a symptom.

So you see it as a consequence of the symptom –

Yeah, a consequence of the symptom rather than a symptom itself.

Right.

Well, okay. Another question. What is the PCL and were can the revised PCLM be found?

I've had some discussions recently with the National Center, and they're still in the process of finalizing it as far as I know.

Okay. All right. And maybe you can give some background of what the PCL is?

And I do want to comment on just screening tools in general. We are widely using in our clinics, I know in DOD and VA, and I'm sure in a lot of civilian practice settings, the PHQ2, the PHQ9 for depression, those are still totally valid. There's no less validity now with the new diagnosis. The generalized anxiety, the GAD7, for instance, it's completely valid with the new criteria. The audit, and the audit C for alcohol use disorders, it is as valid now as it was then because essentially symptoms haven't changed over all. And as a screening tool, it's perfectly valid. But PTSD there's a four-question primary care screener. I don't really see any difference, any need to have a difference, and I think it's just as valid now with the four questions as previously. The PTSD checklist, the PCL, is undergoing some changes. It is going to be updated so that it reflects 20 symptoms instead of 17. But in the meantime, the 17 symptoms PCL is a very highly-validated instrument that's been widely used, and there's no reason why clinicians can't continue to use that for the time being.

Actually there's a follow-up question. The PCL is widely used in the VA. When can, or when should, we being using the newer version? Is it available to use currently? And I guess you already answered that.

Yeah, again, I think that the National Center is probably in the process of finalizing that. But I think it needs some validation work before it's put out there for widespread use. I mean, I don't think we have sufficient validity data yet on it. That's my opinion again.

Right. Well it will be curious to check back with the National Center and find out what their official position is.

Okay, so this is an interesting question. Without the GAF, how will providers accurately describe the patient from a social occupational perspective? So without the GAF, you know, how do you sort of squeeze in the functioning?

The GAF has never really panned out in terms of validity. But there are other instruments out there that are used very widely and have very good validity including the WHO Disability Assessment Scale, the WHODAS. And the current DSM, although there is no axis five, they are recommending the use of the WHODAS in evaluating individuals. I think that that's good, particularly for chronic illnesses. But when you get into, for instance, healthy active duty soldiers, you know, in a DOD healthcare system, I'm not sure the WHODAS is necessarily going to be the best instrument because the physical functioning items have more to do with severe disability, like ability to dress oneself, or ability to walk a kilometer. These are things that are probably not the best measures for active duty individuals.

Right. So one of the participants wanted to know more about WHODAS, and the issue is the WHODAS may be more applicable for medical conditions, or maybe in the VA population, but less relevant in an active duty population.

That's my opinion. There is ongoing discussions about what the most optimal measure is for functioning, to measure functioning or measure global symptoms, global distress.

Right.

That's an ongoing issue that a lot of clinics and healthcare systems are dealing with.

Right. And I think even from the DOD perspective, we are grappling with what's the best measure of functional impairment.

Right.

So another question from the audience. Are the changes only in wording, or do they reflect some clinical understanding?

Specifically PTSD changes, I assume, in this question.

Yes.

Again, I think that the evidence-based changes include the removal of A2 and the splitting of the avoidance into its own category. I think those have good, solid research foundations. I think some of the other changes are, you know, I' m not sure exactly what the evidence is to support those individual wording changes, or whether some of the wording changes were necessary. We're kind of used to 25 years of certain wording. And the reality is that you are going to have individuals who meet the DSM-4 criteria who don't meet the DSM-5 criteria. And that's going to create obviously some concerns for individuals who have the diagnosis under the previous version. In the test, retest reliability trials, there was about a ten percent decrease in prevalence using the new criteria compared with the prevalence of the condition in the population that they were looking at. In our study we found as much as 30% lower prevalence, so, again, but that's using some initial questions that aren't exactly the way they are now. So, you know, this is an area where we're going to have quite a bit more work to do.

Right. You know perhaps the second webinar should focus on PTSD from the developer's standpoint of view, you know, invite some of the folks who developed the criteria.

Absolutely.

And dig into –

Yeah. Versus Hoge's opinions.

That's right.

Exactly.

All right. So what will happen to individuals who have been diagnosed with disorders that are no longer included in DSM-5 such as Asperger's?

Well, that specific question is not an area that I'm an expert in, per se, but I think there was quite a bit of thought that went into that new autism spectrum disorder, and I think that the majority of individuals with Asperger's is going to fit into that autism spectrum, and autism spectrum encompasses the diagnose of Asperger's as well as some other conditions that were listed in that previous chapter. So there's been quite a bit of debate, specifically about the Asperger's diagnosis, the removal of the Asperger's diagnosis, but there's quite a bit of research that supports the decisions that were made.

Right.

As far as I understand.

Okay. So do you think the new PTSD definition – I guess we've covered the prevalence of PTSD quite a bit and how DSM-5 affects the prevalence rates of PTSD. What is your recommendation if you have a soldier or sailor or a Marine who meets PTSD criteria in DSM-4TR, but does not meet criteria if you use the new diagnostic criteria with DSM-5.

Well, you know, that's a very interesting question. And the fact of the matter is that these changes are all consensus – they're consensus-based changes. There is research that supports – there's research that backs up the changes, but, in the end, when people are sitting down and writing well how are we going to exactly word this, these are consensus-based changes that we don't know yet the degree of validity of many of these changes. So if I have a soldier, for instance, who's met the DSM-4TR definition of PTSD, they have a diagnosis of PTSD, I'm not going to change it just because they don't quite meet the new criteria of DSM, at least until there's more research looking at the validity of these changes.

Right.

That's my personal thing. I think people may be horrified to hear me say that, but I think there's enough questions about how the meaning of some of these items changed and the fact that some of the items there were quite a bit lower prevalence of endorsement with the new changes. So I think that it's an open question.

Right. I think the other concern that occurred to me when you were talking about the depressive symptoms being disarticulated from the main avoidance criteria is although the majority of patients with PTSD have co-morbid depression, there is about 30 to 40% who do not have co-morbid depression, so how would they be classified. You know, if they don't have co-morbid depression, they would not fulfill criteria for that particular depressive cognition. So it will be interesting to see.

Yeah. Well, you know, they now have seven symptoms in that mood and cognition symptom category –

Right.

And you only need two of them.

Right.

So –

So the bar is pretty low?

The bar is pretty low, at least within that category.

Right.

A little bit of Ann Hedonia will put you in that category.

So is the timeframe of acute stress disorder the same, and what about the timeframe for PTSD?

Yeah, and I actually had a slide prepared, but we sort of ran out of time, but yes, the time – all of the timeframes – well actually, the acute stress disorder, I think it went from –

Two days to three days, right?

Two days – two to 30 days, now it's three to 30 days.

Right.

Okay. I'm sure there was a good reason for that change. But basically, less than one month, acute distress disorder. Greater than one month is PTSD. And the other specifiers are also the same. In PTSD they've added a dissociation specifier, which is new.

Right. Right. So let's see. I'm not sure if I understand this question. What is specified trauma disorder? What would fall into this category?

Okay. So that's a good question. So, again, as I mentioned, in each of these chapters instead of, for instance, depression NOS, they now have other depressive disorder specified and unspecified

I see.

Codes. Okay. And then the trauma disorders, instead of a trauma disorder NOS, yeah, they now have other specified and stressor-related disorder categories, and one of the examples is (inaudible), which is a cultural reaction that occurs in certain populations, and there are lot of other cultural symptoms that can happen after traumatic events. They also include persistent complex bereavement disorder, which we talked about earlier, and they cite that as an example of a specified trauma and stressor-related condition. And, again, that's going to be interesting to see how that plays out because in my read, I mean a lot of the soldiers that I see with PTSD, they would easily meet the definition of the persistent complex bereavement disorder. So I don't know if I answered the question.

Yes. I think it's going to take a little getting used to from getting out of the NOS category and talking about specified trauma disorder. It's going to take a little getting used to.

Right.

Okay. I'm going to take one more question and then we're going to wrap up. Can you tell us anything about the research associated with internet gaming disorder? Doesn't seem to fall in line with the concept of spectrums so far in DSM-5. But I think what I would like you to address in addition to that is where does gambling fit in, if you don't know much about internet gaming disorder.

Well, gambling disorder, which was previously I think in impulse control disorders I think is where it was before. It's been moved into substance use disorders, and it looks like fairly similar criteria as what was there before. And the internet one is, I believe, in the research conditions for further study. So there's several things that are in the conditions for further study, and let me verify that because I actually don't know for sure, but I believe that's in the conditions for further study.

The internet gaming –

Yeah. It is. It is.

Okay.

Yeah. Conditions for further study.

So are you aware of any research associated with the internet gaming –

No, I'm not up on that.

Not your area of expertise?

Not my area of expertise, yeah.

Okay. Great. All right. So this is an interesting question, and, you know, we'll make the answer very brief. Will other assessments such as clinician-administered PTSD scale, the CAPS, be also updated to reflect the new DSM-5 changes?

Yes, that's in the works, too.

Right. So that's going to be a lot of work related to validating the CAPS before rolling it out.

Right.

Okay. Well, thank you again for a terrific webinar, Dr. Hoge. Today's presentation will be archived in the monthly webinar section of the DCoE website. To access this presentation and resource list for this webinar, visit the DCoE website at dcoe.health.mail/webinars. An edited transcript of the closed captioning will be posted to that link and audio recording of this webinar will also be available as a downloadable podcast.

To help us improve future webinars, we encourage you to complete a feedback survey including your feedback about the format of this webinar. This link is available, again, on the DCoE website.

The next DCoE webinar topic is traumatic brain injury 101, and is scheduled for August 15, 2013, from 1300 to 1430.

Thank you so much, Dr. Hoge, for a fantastic presentation.

My pleasure. Thank you for hosting, and thank you everyone out there for listening. I really appreciate it.

Have a great day everyone.

Take care.

This concludes today's conference. You may disconnect at this time. Thank you.